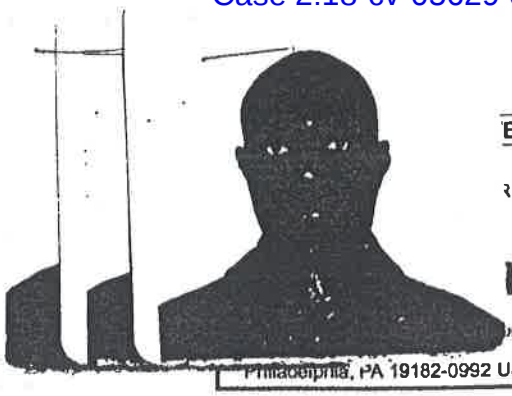
Exhibit 22



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ED STATES MEDICAL LICENSING EXAMINATION™ (USMLE™)

2001 STEP 1 AND/OR STEP 2 APPLICATION

R STUDENTS/GRADUATES OF FOREIGN MEDICAL SCHOOLS REGISTERED BY
THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES
TELEPHONE: (215) 386-5900 INTERNET: http://www.ecfmg.org

reign Medical Graduates
Philadelphia, PA 19182-0992 USA

OR

VERY IMPORTANT
via courier service to:
ECFMG
3624 Market Street
Philadelphia, PA 19104-2685 USA

NOTE: All items on all sides of the application must be filled out completely for initial and reexamination or application will be rejected.
Use typewriter or print carefully in ink using uppercase letters.

PART A — BIOGRAPHICAL INFORMATION

1 ECFMG EXAMINATION HISTORY: Have you ever submitted an application to ECFMG for **any** examination, even if you did not take the examination? ☐ Yes ☒ No
If yes, enter your USMLE/ECFMG Identification Number in the following boxes: ☐-☐☐☐-☐☐☐-☐ N/A

2 NAME:

FEMI — First Name
CHARLES — Middle Name
IGBERAESE — Last Name (Surname/Family Name)

2a PREVIOUS/MAIDEN NAME: N/A

First Name
Middle Name
Last Name (Surname/Family Name)

3 MAILING ADDRESS:

16327 CHADSFORD AVENUE — Street Address/Post Office Box
Address Continued
BATON ROUGE — City (Include Postal Code as required for non-USA/non-Canadian address.)
LOUISIANA — State/Province
70817 — Zip/Postal Code
USA — Country

3a TELEPHONE NUMBER, FAX NUMBER AND E-MAIL ADDRESS:

Country Code
225 — City/Area Code
753-8809 — Telephone Number
City/Area Code
Fax Number
E-Mail Address: CFemi@hotmail.com

4 U.S. SOCIAL SECURITY AND/OR NATIONAL IDENTIFICATION NUMBERS:

N/A — U.S. Social Security Number
National Identification Number
Country

5 BIRTHDATE/BIRTHPLACE:

Day 17 Month 04 Year 1962
Location: City: LAGOS
Province: LAGOS Country: NIGERIA

6 GENDER: ☒ Male ☐ Female

7 NATIVE LANGUAGE:

8 CITIZENSHIP:

A. At Birth: ☐ USA or ☒ Other (Specify) NIGERIAN
B. Upon Entering Medical School: ☐ USA or ☒ Other (Specify) NIGERIAN
C. Now: ☐ USA or ☒ Other (Specify) NIGERIAN

9 ETHNICITY: Provision of the following information is voluntary. See *Instructions* for details.

1 ☐ American Indian/Alaskan Native
2 ☐ Asian/Pacific Islander
3 ☐ Hispanic
4 ☒ Black (not of Hispanic Origin)
5 ☐ White (not of Hispanic Origin)
6 ☐ Other

EXHIBIT 10
Kelly
10 8/20/11
PENGAD 800-631-6989

OERAESE FEMI CHARLES
(Last, First, Middle)

Enter your USMLE/ECFMG Identification Number, if one has been assigned to you: N/A

PART B — REGISTRATION INFORMATION

ELIGIBILITY PERIOD:

✓	STEP 1 — ELIGIBILITY PERIOD
☐	November 1, 2000 – January 31, 2001*
☒	December 1, 2000 – February 28, 2001* ✓
☐	January 1, 2001 – March 31, 2001*
☐	February 1, 2001 – April 30, 2001
☐	March 1, 2001 – May 31, 2001
☐	April 1, 2001 – June 30, 2001
☐	May 1, 2001 – July 31, 2001
☐	June 1, 2001 – August 31, 2001
☐	July 1, 2001 – September 30, 2001
☐	August 1, 2001 – October 31, 2001
☐	September 1, 2001 – November 30, 2001
☐	October 1, 2001 – December 31, 2001

✓	STEP 2 — ELIGIBILITY PERIOD
☐	November 1, 2000 – January 31, 2001*
☐	December 1, 2000 – February 28, 2001*
☒	January 1, 2001 – March 31, 2001* ✓
☐	February 1, 2001 – April 30, 2001
☐	March 1, 2001 – May 31, 2001
☐	April 1, 2001 – June 30, 2001
☐	May 1, 2001 – July 31, 2001
☐	June 1, 2001 – August 31, 2001
☐	July 1, 2001 – September 30, 2001
☐	August 1, 2001 – October 31, 2001
☐	September 1, 2001 – November 30, 2001
☐	October 1, 2001 – December 31, 2001

*USMLE Step 1/Step 2 are not offered during the first two weeks of January.

(11) TESTING REGION AND INTERNATIONAL TEST DELIVERY SURCHARGE:

✓	STEP 1 — TESTING REGION	SURCHARGE
☐	Africa	$100
☐	Asia	$100
☐	Australia	$100
☐	China (For Hong Kong, select Asia testing region.)	$100
☐	Europe	$125
☐	India	$100
☐	Indonesia	$100
☐	Japan	$245
☐	Korea	$125
☐	Latin America	$100
☐	Middle East (For Tel Aviv, select Europe testing region.)	$100
☐	Thailand	$100
☐	Taiwan	$125
☐	United States and Canada	$0

✓	STEP 2 — TESTING REGION	SURCHARGE
☐	Africa	$110
☐	Asia	$110
☐	Australia	$110
☐	China (For Hong Kong, select Asia testing region.)	$110
☐	Europe	$140
☐	India	$110
☐	Indonesia	$110
☐	Japan	$270
☐	Korea	$140
☐	Latin America	$110
☐	Middle East (For Tel Aviv, select Europe testing region.)	$110
☐	Thailand	$110
☐	Taiwan	$140
☐	United States and Canada	$0

(12) FEES:

STEP 1 — FEES

12.1 Examination Fee $ 615.00

12.2 Enter amount of the International Test Delivery Surcharge for the testing region you selected above: + .00

12.3 TOTAL STEP 1 FEE = $ .00

STEP 2 — FEES

12.4 Examination Fee $ 615.00

12.5 Enter amount of the International Test Delivery Surcharge for the testing region you selected above: + .00

12.6 TOTAL STEP 2 FEE = $ .00

(13) TOTAL FEE(S) FOR ALL EXAMS:

Add the amounts on lines 12.3 and 12.6 and enter total at right: $ 1,230.00

(14) PAYMENT — Check method of payment and complete all information requested for that payment method

☐ Charge my credit card. Check One: ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number:

Total Exam Fee(s): $ .00

Credit Card Processing Fee + 20.00

Total Amount = $ .00

Expiration Date: / (MONTH / YEAR)

Address of Card Holder:

Name of Card Holder:

Signature of Card Holder:

☒ My check, bank draft or money order, made payable to ECFMG, is enclosed.

Total Amount: $1,230

☐ I have sent a wire transfer to ECFMG.

Date sent:

Originating bank:

Total Amount: $

Bank Reference Number:

Name of sender, if different from applicant:

You must send full payment of the total amount with this application form. If you do not include full payment, this application will be rejected.

(15) EXAMINEES WITH DOCUMENTED DISABILITIES

I have a documented disability covered under the Americans with Disabilities Act and am requesting test accommodations for the exam(s) selected above. ☐ Yes ☒ No

Name: IGBERAESE FEMI CHARLES (Last, First, Middle)

Enter your USMLE/ECFMG Identification Number, if one has been assigned to you: N/A

PART C — MEDICAL EDUCATION INFORMATION

15. MEDICAL SCHOOL NAME AND ADDRESS

List the exact name and address of the medical school from which you graduated or expect to graduate.

Official Name of Medical School: UNIVERSITY COLLEGE HOSPITAL IBADAN

Street Address: 1

City: IBADAN | State/Province: UNIVERSITY OF IBADAN | Postal Code:

Country: NIGERIA | University Name (if applicable):

16. MEDICAL SCHOOL INFORMATION:

- **Attendance Dates:** From 06 / 1982 (MONTH / YEAR) to 06 / 1987 (MONTH / YEAR)
- Number of Years Attended: 5
- Date you graduated (or expect to graduate): 06 / 1987 (MONTH / YEAR)
- Date your medical diploma was issued (or expect to be issued): 06 / 1987 (MONTH / YEAR)
- **Title of Medical Degree you received or will receive:** MBBS

Refer to the "Reference Guide for Medical Education Credentials" on pages 45-48 of the 2001 *Information Booklet* for the list of medical degrees required by ECFMG.

17. STATUS OF MEDICAL SCHOOL STUDENT — *Must be completed by all students:* N/A

- If you are applying for **Step 1**, will you have completed 2 years of medical school by the beginning of your requested eligibility period (see PART B, 10) and are you now officially enrolled and will you be officially enrolled at the time you take the exam? Check yes or no: ☐ Yes ☐ No
- If you are applying for **Step 2**, will you be within 12 months of completion of the formal didactic curriculum at your medical school by the beginning of your requested eligibility period (see PART B, 10) and are you now officially enrolled and will you be officially enrolled at the time you take the exam? Check yes or no: ☐ Yes ☐ No

18. STATUS OF MEDICAL SCHOOL DIPLOMA -- *Must be completed by all graduates:*

If you have graduated from medical school, you must include 2 photocopies of your medical diploma if you have not sent them previously. If you graduated from medical school but your medical diploma has not yet been issued, you must submit with your application a letter signed by your Medical School Dean, Vice Dean or Registrar that confirms you graduated from medical school, have met all requirements to receive your medical diploma and states the date your medical diploma will be issued. (See "Provision of Credentials and Translations" on page 22 of the 2001 *Information Booklet*.)

Graduates must check one:

- [X] I have graduated from medical school and am enclosing 2 photocopies of my medical diploma.
- [ ] I have graduated from medical school and have previously submitted to ECFMG 2 photocopies of my medical diploma.
- [ ] I have graduated from medical school, but my medical diploma has not yet been issued. I am enclosing a letter from my medical school that confirms I graduated, have met the requirements to receive my medical diploma and states the date my medical diploma will be issued.

Note: Your application will be rejected if you graduated from medical school and have not submitted photocopies of your medical diploma or a letter from your medical school that confirms your graduation (as described above).

19. OTHER MEDICAL SCHOOL(S) ATTENDED -- Continue on a separate sheet of paper, if necessary:

List the names, addresses and dates of attendance of all other medical schools you attended. N/A

Official Name of Medical School

Street Address

City | State/Province | Postal Code

Country | University Name (if applicable)

Attendance Dates: From / (MONTH / YEAR) to / (MONTH / YEAR)

20. TRANSFER CREDITS:

Did you transfer academic credits from any school(s) to the medical school that conferred or will confer your medical degree? ☐ Yes [X] No

If Yes, indicate on a separate sheet of paper the name of the school(s) from which the credits were transferred, the number of credits transferred and the course titles for all credits transferred.

21. MEDICAL LICENSURE:

Date you received an unrestricted license or certificate of full registration to practice medicine: 8 / 1989 (MONTH / YEAR)

Country or state in which you are licensed: LAGOS, NIGERIA

22. EMPLOYMENT -- Present employment only. NONE

Institution/Company Street City/State/Country	Position(s)	Dates

PART C CONTINUES ON THE REVERSE SIDE.

N/A

Name: IGBERAESE FEMI CHARLES (Last, First, Middle)

Enter your USMLE/ECFMG Identification Number, if one has been assigned to you:

PART C — MEDICAL EDUCATION, LICENSURE AND EMPLOYMENT INFO

18. CERTIFICATION BY APPLICANT

Students and graduates must sign the application in the presence of their Medical School Dean, Vice Dean or Registrar. (See 19.2.A below.)

If a graduate cannot sign the application form in the presence of a medical school official noted above, he/she must sign the application form in the presence of a Consular Official, First Class Magistrate or Notary Public (See 19.2.B below) *and* must explain in writing why the application form could not be signed in the presence of a medical school official. (See 19.2.B.1 below.)

Application forms are to be mailed to ECFMG from the office of the official or notary who witnesses the applicant's signature. All information on the application form is subject to verification and acceptance by the Educational Commission for Foreign Medical Graduates.

I hereby certify that I currently meet examination eligibility requirements and that the information in this application is true and accurate to the best of my knowledge and that the photographs enclosed were taken within 6 months of the date of this application.

I also certify and acknowledge that I have reviewed the appropriate edition (that which pertains to the eligibility period for which I am registering, PART B, 10 above), of the ECFMG *Information Booklet* and USMLE *Bulletin of Information*, am aware of the contents of both sections, meet the eligibility requirements set therein and agree to abide by the policies and procedures therein.

I understand that (1) falsification of this application, or (2) the submission of any falsified educational documents to ECFMG, or (3) the submission of any falsified ECFMG documents to other agencies, or (4) the giving or receiving of aid in the examination as evidenced either by observation at the time of the examination or by statistical analysis of my answers and those of one or more other participants in that examination, or engaging in other conduct that subverts or attempts to subvert the examination process, may be sufficient cause for ECFMG to bar me from the examination, to terminate my participation in the examination, to withhold and/or invalidate the results of my examination, to withhold a certificate, to revoke a certificate, or to take other appropriate action. (See page 15 of the 2001 *Information Booklet* for additional details concerning Validity of Scores and Irregular Behavior.)

I understand that the Standard ECFMG Certificate and any and all copies thereof remain the property of ECFMG and must be returned to ECFMG if ECFMG determines that the holder of the Certificate was not eligible to receive it or that it was otherwise issued in error.

I hereby authorize the Educational Commission for Foreign Medical Graduates to transmit any information contained in this application, or information that may otherwise become available to ECFMG, to any federal, state or local governmental department or agency, to any hospital or to any other organization or individual who, in the judgment of ECFMG, has a legitimate interest in such information

Seal or stamp of official *must cover* a portion of the attached photograph.

Signature of Applicant (In Latin Characters) X _____ (Signature must match full legal name as given in PART A-2.)

Date: 18 / 10 / 2000 (Day / Month / Year)

19.2.A CERTIFICATION BY MEDICAL SCHOOL OFFICIAL (*Must* be completed for medical school students):

N/A

I hereby certify that the photograph, signature, and information entered in all parts of Section 15 of this form, including medical school and attendance dates, accurately apply to the individual named above, and that this individual is: (*must* check one) ☐ *officially enrolled in* or ☐ *a graduate of* the institution indicated below. I have affixed the medical school seal or stamp over a portion of the photograph above.

Signature of Medical School Official (In Latin Characters) X _____ Date: Day / Month / Year

Print Name and Official Title (In Latin Characters with English translation, where applicable.) Institution

My Commission Expires July 20, 2004

OR

19.2. B CERTIFICATION BY IDENTIFICATION WITH EXPLANATION (Pertains to graduates only):

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements in this document are subscribed and sworn to before me by the applicant on this 19 day of the month of OCT 10, in the year 2000.

X _____

Signature of Consular Official, First Class Magistrate, Notary Public (In Latin Characters with English translations, where applicable.) Official Title

19.2.B.1 EXPLANATION (Pertains to graduates only) – Explain in the space below why the application could not be signed in the presence of your Medical School Dean, Vice Dean or Registrar. This explanation must be acceptable to ECFMG and must be provided each time you submit an application to ECFMG.

MY MEDICAL SCHOOL IS OVERSEAS AND THE MAIL SYSTEM IS VERY UNRELIABLE.

20. CLINICAL CLERKSHIPS — Continue on a separate sheet of paper, if necessary:

Clinical Discipline	Hospital/Clinic	Location (exact address)	Supervising Physician	Dates of Clerkship
SURGERY	NEW ERA HOSPITAL	WARRI, NIGERIA	DR ODIAMEN	12/87 – 2/88
OBGYN	NEW ERA HOSPITAL	WARRI, NIGERIA	DR AIGBOJIE	3/88 – 6/88
PEDIATRICS	NEW ERA HOSPITAL	WARRI, NIGERIA	DR OSAGIE	7/88 – 10/88

PART D — OTHER EXAM HISTORY AND APPLICANT NUMBERS

21. OTHER EXAM HISTORY and APPLICANT NUMBERS:

Check below the **organizations** (other than ECFMG) to which you previously applied for examinations. Enter the date of the most recent examination that was administered to you and the identification number that was assigned to you **by that organization.**

N/A

☐ NATIONAL BOARD OF MEDICAL EXAMINERS

Applicant Identification Number: NBME Parts I/II

Date of Most Recent Examination Taken: Month / Year 19

Applicant Identification Number: USMLE Steps 1/2

Date of Most Recent Examination Taken: Month / Year

N/A

☐ STATE LICENSING AUTHORITY IN THE UNITED STATES

FIN – Federation Identification Number: FLEX

Date of Most Recent Examination Taken: Month / Year 19